Weitzman Institute
inspiring primary care innovation

The France Foundation

Weight MANAGEMENT *in* Community Health:

Bridging Systems & Care Coordination

Harvest and Next Steps

Learning Collaborative Session #8

Today's Agenda

- Welcome
- Overview of Technology and Reminders
- Learning Collaborative Takeaways
- FQHC's Plans for Improvement
- Next and Final Steps

Technology: Your Zoom Window

Sound

- Muting/Unmuting
- Press *6 to unmute phone audio

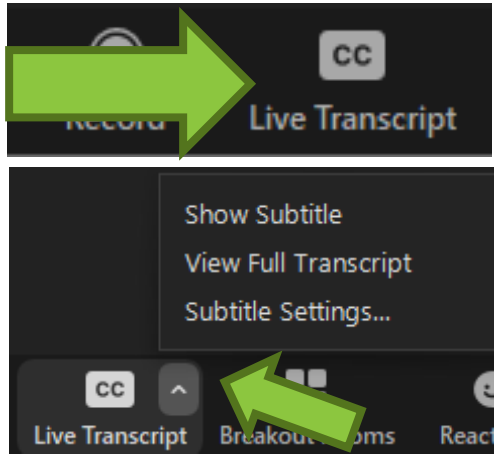
Webcam

- Please share!

Chat

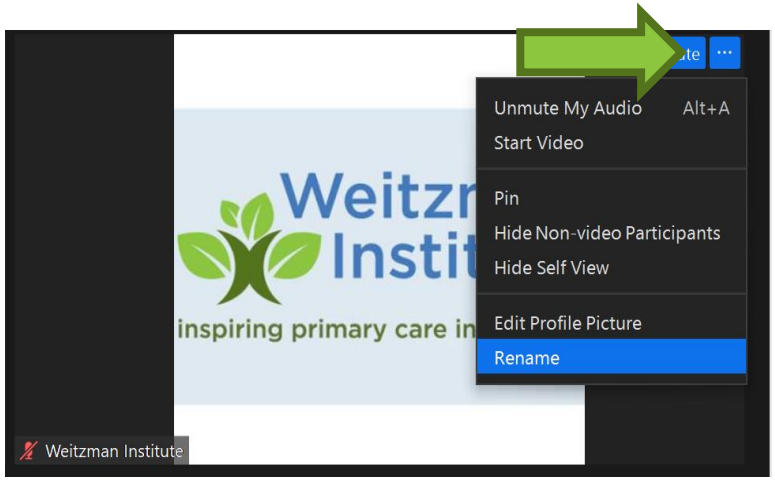
- Questions
- Sharing resources/ideas

Technology: Your Zoom Window



Closed Captioning and Live Transcript

- Click on the caret or icon
- Select ‘Show Subtitle’ for closed captioning on screen
- Select ‘View Full Transcript’ for live transcript pop-out window



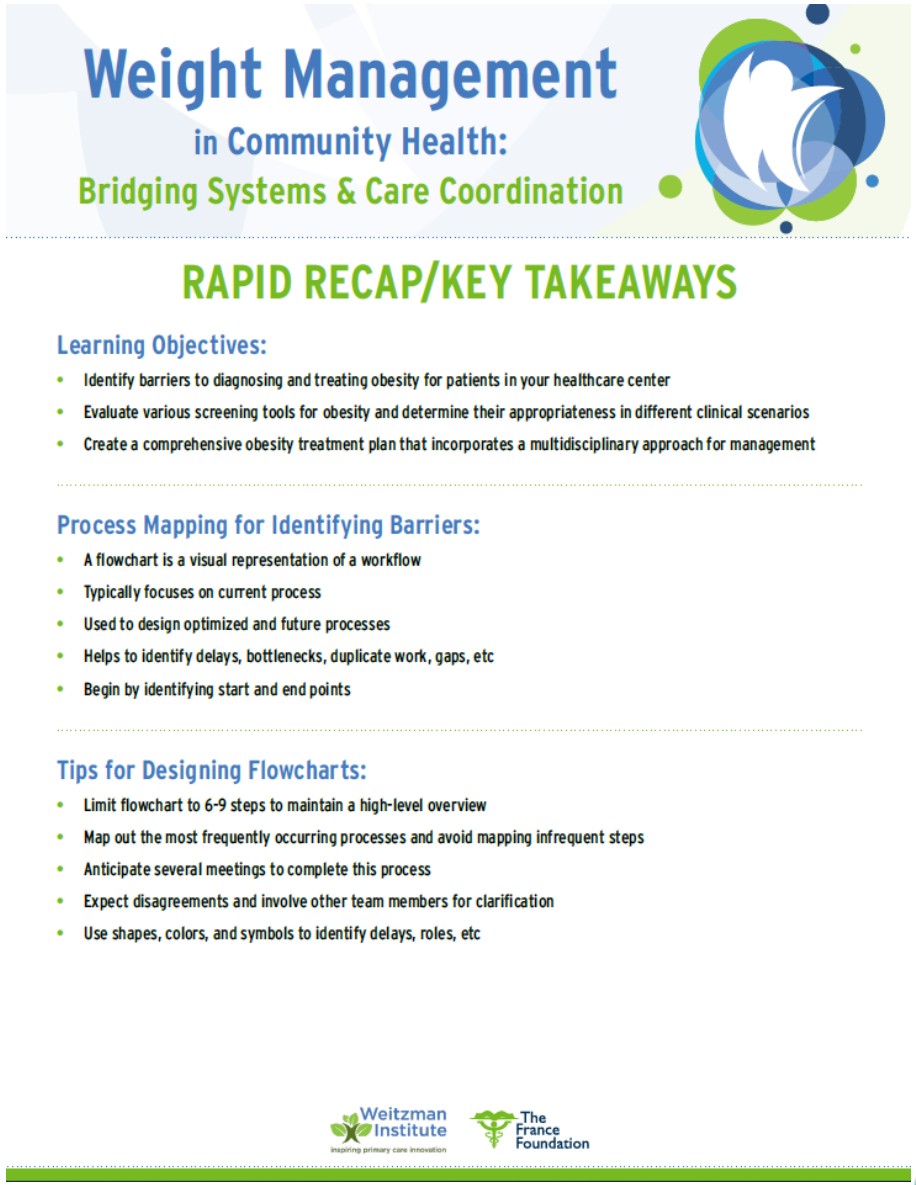
Change Your Name

- Click on the three dots
- Click ‘Rename’
- Type in your name

Rapid Recaps

- Return to the **Overview** tab of the live activity, *Live Session–Module 7: System/Clinic Transformation and Sustainability*
- Scroll down to the **Rapid Recap** header

You will then be able to click on **Rapid Recap,** listed below the headers, to access the resources



Continuing Education Credits

In support of improving patient care, this activity has been planned and implemented by The France Foundation and Moses/Weitzman Health System, Inc. and its Weitzman Institute. The activity is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the health care team.

JOINT ACCREDITATION™
INTERPROFESSIONAL CONTINUING EDUCATION

This series is intended for clinical leadership, primary care providers, behavioral health providers, dietitians, nurses, QI/technical teams, and other members of the care team.

Please complete the post-session survey and claim your CE certificate on the WeP after today's session.

Disclosure

- With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship between the party listed above (or spouse) and any for-profit company in the past 12 months that would be considered a conflict of interest
- The views expressed in this presentation are those of the presenter and may not reflect official policy of Moses/Weitzman Health System and its Weitzman Institute
- We are obligated to disclose any products that are off-label, unlabeled, experimental and/or under investigation (not FDA-approved) and any limitations on the information that we present, such as data that are preliminary or that represent ongoing research, interim analyses, and/or unsupported opinion

Acknowledgements

- This activity is supported by an independent medical educational grant from Lilly

The Weitzman Institute is Committed to Justice, Equity, Diversity & Inclusion

At the Weitzman Institute, we value a culture of equity, inclusiveness, diversity, and mutually respectful dialogue. We want to ensure that all feel welcome.

If there is anything said in our program that makes you feel uncomfortable, please let us know.

Series Learning Objectives

- Ascertain metrics of your healthcare center against key performance measures related to the obesity care
- Identify barriers to diagnosing and treating obesity for patients in your healthcare center
- Formulate an improvement plan for establishing diagnostic and treatment plans for patients with obesity in your healthcare center
- Develop an improvement plan for managing holistic care of patients with obesity in your healthcare center

Session Learning Objectives

- Understand the stages of team growth during QI initiatives
- Present key learnings and provide feedback to other healthcare centers on their proposed QI initiatives

Weight Management in Community Health: Bridging Systems and Care Coordination

8-Session Learning Collaborative

Session by Session QI & Change Strategy Tools

1 Intro to Data and QI

Establish a Sense of Urgency

Tools

- Baseline Data

2 Environmental Scan

Create Guiding Coalition

Tools

- Stakeholder Analysis
- Project Charter
- Problem Statement

3 Screening and Assessment

Develop Vision

Tools

- Process Mapping
- SWOT Analysis
- Fishbone Diagram
- Global Aim
- Specific Aim

4 Prevention, Management & Treatment

Communicate Vision

Tools

- PDSA
- Communication Plan

5 Patient & Family Engagement

Empower to Act

Tools

- Stakeholder Analysis

6 Motivational Interviewing

Generate Short-Term Wins

Tools

- Influencing Strategy
- Consult With Sponsors, Supporters, Leadership
- Celebrate Wins

7 System/Clinic Transformation & Sustainability

Consolidate Gains

Tools

- Standardize and Spread (SDSA)

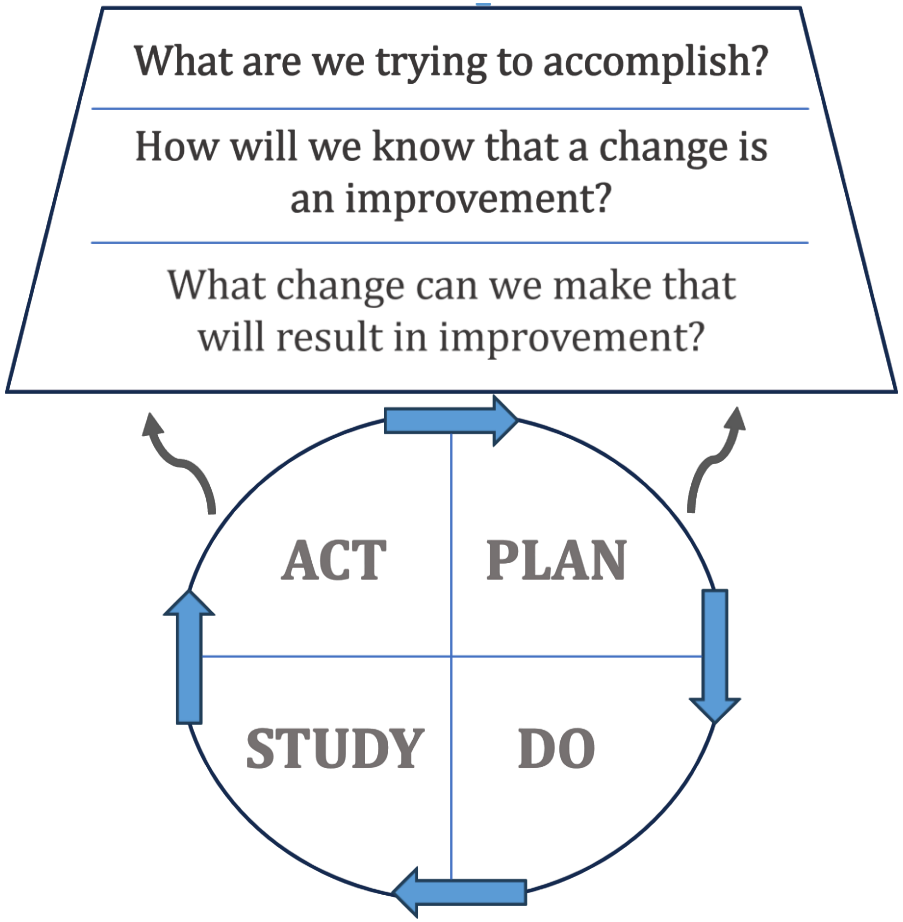
8 Harvest & Next Steps

Anchor Change in Culture

Tools

- Communication Plan
- Policy Change Documentation
- Establish Check-In Strategy

The Model for Improvement



Langley, G. J., Moen, R., Nolan, K. M., Nolan, T. W., Norman, C. L., & Provost, L. P. (2009). *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd ed.). San Francisco, CA: Jossey-Bass Publishers.

Key Takeaways

- Quality improvement is a continuous process of assessment and development

Clinic Presentation Guidelines

- Each presenter will have **3 minutes** to speak
  - When there are **30 seconds left**, a reminder chime will play to help keep track of time
- After each presentation, the QI coaches and Dr. Brar will provide 3 minutes of high-level feedback
- We encourage all of you to **share your thoughts and feedback using the chat function**

Centerpoint Health

PLAN:

Current Practices/Processes Related to QI Initiative:

- We are currently tracking BMI
- If already working with the primary provider on the team, patients with overweight and obesity are referred to the RDN for nutrition counseling
- If referred to RDN by a different provider, patients that express interest in weight loss medication are scheduled with the primary provider on the team by the RDN
- All patients meeting with the RDN and/or primary provider are given resources for local gyms and/or behavioral health referrals

Prediction: What Change Will Be Tested or Implemented?

- Streamlining and enhancing current practices by improving coordination and workflow with the rest of the CPH team will lead to a 3% average BMI reduction among participants and increased engagement in available resources

Anticipated Barriers:

- Patients declining referrals or follow-up
- Limited patient knowledge about weight management options (e.g., medications, gym resources)
- Providers may lack enough knowledge and/or experience to feel comfortable prescribing medications
- Insurance coverage of medications
- Lack of coordination and communication with other parts of the health care team
- Lack of protocol for identifying enrolled patients

DO:

- Enhanced EMR alerts were implemented to streamline referrals
- RDN conducted initial counseling sessions with 85% of referred patients and provided education materials to 95%-100% of those patients
- Behavioral health and local gym discount information was provided to 90% of patients seen for weight loss counseling

STUDY:

Prediction: Streamlining and enhancing current practices by improving coordination and workflow with the rest of the CPH team will lead to a 3% average BMI reduction among participants and increased engagement in available resources

Family Health Center d/b/a Sunset Park Health Council Inc.

PLAN:

Current Practices/Processes Related to QI Initiative:

- For behavioral health specific visits, in-person visits occur for medication management and psychiatric evaluations. While the MA/RN is supposed to measure height and weight at in-person visits, current compliance is at 32%
- Currently, no workflow exists for communicating to the behavioral health provider that their patient has an abnormal BMI
- We do not have an alert for all patients with BMI > 25 to be counseled, nor for their medications to be reviewed to see whether any medications that cause weight gain can be altered. At this time, 18% of patients with BMI > 25 are counseled

Prediction: What Change Will Be Tested or Implemented?

- We will test the number of patients seen in person who have a BMI taken, addition of EHR alert, and counseling documented
- The MA/ RN will obtain the weight/height
- The MA will alert the provider in Epic of abnormal BMI and recommend they look at the BPA alert
- The behavioral health provider will need to open the Epic alert and counsel the patient accordingly

Anticipated Barriers:

- MA/RN may not be used to checking height and weight on every patient, so their workflow may need to be altered
- Multiple EHR alerts exist for behavioral health providers already, so they may not click on an additional alert
- It may take time to implement a new EHR alert into Epic
- Time constraint during the visit may limit the provider's ability to counsel patients

DO:

- We met with behavioral health leadership to discuss the feasibility of adding an alert to nudge providers. They shared that behavioral health providers have multiple different alerts that fire, which makes it difficult for the provider, and recommended the use of an MA to nudge the provider about the alert if the BMI is abnormal
- We met with behavioral health nursing leadership to discuss how to identify patients coming in for in-person visits where height/weight should be taken
- We met with our informatics team to discuss the feasibility of incorporating a BPA and whether a smart phrase should first be piloted for counseling to assess feasibility and language

STUDY:

Prediction:

- We will test the number of patients seen in person who have a BMI taken, addition of EHR alert, and counseling documented
- The MA/ RN will obtain the weight/height
- The MA will alert the provider in Epic of abnormal BMI and recommend they look at the BPA alert
- The behavioral health provider will need to open the Epic alert and counsel the patient accordingly

Northeast Valley Health Corporation

PLAN:

Current Practices/Processes Related to QI Initiative:

- Currently, scrubbing takes place 1-2 days before the visit and includes printing of i2i sheet. If patients are added on to the schedule the same day, there is inconsistent scrubbing and printing of i2i sheet

Prediction: What Change Will Be Tested or Implemented?

- Primary MA for each provider constantly reviews schedule for added patients, and prints or asks float MA to print i2i sheet

Anticipated Barriers:

- Lack of staffing if there are call-outs
- Changes in the schedule fluctuate over the course of the day: may need to check multiple times per day

DO:

- 12/6: Provider Jacobs for the AM session
- All i2i sheets printed for all visits except for the flip visit, no i2i sheet was printed
- No same days were added to that session, except the flip visit
- 12/6: Provider Jacobs for the PM session
- A i2i sheet is printed for all visits expect one appointment that was scheduled after the MA had completed scrubbing
- No i2i sheet printed for the same-day appointment
- 12/6: Dr. Walford Adult session AM
- Missing i2i sheet for all telephone appointments (three of them)
- No i2i sheet for new patient, expected
- All other i2i sheets were there
- No same-day appts were added
- 12/6: Dr. Lwin Adult session PM
- All i2i sheet is printed for session, except one, the 3:20 pm appt
- No same day appts were added

STUDY:

Prediction:

- MAs had 1-3 additional appointments to scrub for—this is not an overwhelming amount. The main MAs had the option to ask the float MA to help with scrubbing/ printing the i2i sheets as well

Quality of Life Health Services (QOLHS), Inc

PLAN:

Current Practices/Processes Related to QI Initiative:

- We are currently tracking BMI but have not had a formal plan of specific interventions to be provided to the patient
- We have not put alerts in place to remind providers to address weight loss

Prediction: What Change Will Be Tested or Implemented?

- We will test whether providing weight loss management materials and dot phrases will increase obesity care being addressed on patient encounters
- The provider staff, nursing staff, and QI staff will have primary roles in conducting the study. The provider will ask patients if it is a good time to address weight loss and provide recommendations if patients agree. The nursing staff will review the instructions on the After Visit Summary and give it to the patient. QI staff will run reports
- The study will be conducted at Quality of Life Cherokee Quality Health Care Clinic

Anticipated Barriers:

- Time restraints and busy clinical days
- Patients may not show or reschedule
- Patients' inability to afford medications/healthy foods
- Lack of outside support system/positive community
- SDOH issues like transportations problems

DO:

- The plan has not been carried out yet
- We anticipate that barriers will be identified
- Improvements will be made based on results

STUDY:

Prediction:

- The percentage of patients with obesity that receive counseling and intervention will be increased
- We anticipate improvement in patient outcomes, increased patient encounters, reduction in comorbidities related to obesity and improvement in patient diet and activity

Southside Community Health Services

PLAN:

Current Practices/Processes Related to QI Initiative:

- We are currently placing referrals to CCCMs for patients with uncontrolled hypertension and diabetes
- We are currently calculating BMI at every in-person visit

Prediction: What Change Will Be Tested or Implemented?

- We will test the adherence of referral placement for patients by each clinician, and the addition of EMR alert
- We will regularly connect with clinicians for reminders and education in team meetings and 1:1

Anticipated Barriers:

- Some providers notice and respond to alerts. If they do not, their care team members may not feel comfortable bringing up the missed alert
- The provider may forget to place the referral
- Time constraints and busy clinical days
- Hard to get in the habit of placing certain referrals

DO:

- Of 27 patients, only 5 of them were referred to CCCM
- We had been successful with referrals for the diabetes program
- Repeat training will need to be provided was provided for care teams but was not conducted immediately upon new staff hires

STUDY:

Prediction:

St. Francis House NWA, Inc., d/b/a as Community Clinic

PLAN:

Current Practices/Processes Related to QI Initiative:

- We currently have a new role, Health Coach, within the system. There also are 2 Clinical Pharmacists, 2 RN Case Managers, and 1 nutritionist, as well as a team of Behavioral Health Consultants. Given the limited capacity for the aforementioned team members, a health coaching program is in development and will be accessible to all clinics virtually, if not in person. There will be 15 Board Certified Health Coaches.

Prediction: What Change Will Be Tested or Implemented?

- We will test the current process PCPs use to identify, diagnose, and treat morbid obesity. As noted in the Aim Statement, we will pilot with a single APRN provider at a school-based health center location. We also will test pathways for the PCP team to connect patients with a Health Coach for weight loss services, identifying the most efficient and effective workflows also considering barriers.

Anticipated Barriers:

- Limited time and conflicting schedules for the Collaborative team to meet
- Delay for clinical team to adopt the screening and care coordination workflows
- Limited time for the PCP team to discuss weight loss in depth when screening patients, thus putting them behind schedule
- Language and health literacy barriers
- Patients getting upset when weight loss services were discussed, and associated team discomfort broaching the subject
- Clinical team not scheduling patients with Health Coaches, but rather sending a Referral. Health Coaches then have higher likelihood of not reaching the patient, or of playing phone tag
- Patients declining Health Coach services or cancelling/no-showing appointments.
- SDoH barriers (e.g., temporary or insecure housing, limited healthy food resources, financial insecurity)
- Patient work schedules do not align with clinic hours/Health Coach schedules

HPI:
Weight Mgmt:
Pt interested in Weight Mgmt.

DO:

- The most significant activities included developing efficient standardized processes. Tests of change were preceded by process mapping
- Based on process mapping, the Collaborative team developed & tested an efficient workflow for the MA to inquire about patient interested in weight management services, along with an associated structured field in the EMR
- Additionally, the Health Coach developed structured EMR documentation for the initial intake assessment and continued coaching appointments. The documentation included a combination of template fields and Dynamic Form

STUDY:

Prediction:

- We will test the current process PCPs use to identify, diagnose, and treat morbid obesity. As noted in the Aim Statement, we will pilot with a single APRN provider at a school-based health center location. We also will test pathways for the PCP team to connect patients with a Health Coach for weight loss services, identifying the most efficient and effective workflows also considering barriers

Tandem Health

PLAN:

Current Practices/Processes Related to QI Initiative:

- Currently, providers are referring patients they believe would benefit from weight management and lifestyle intervention to RD and possibly starting weight management medications. Once referral is received, RD is responsible for scheduling and seeing patient for lifestyle intervention with no additional input from other disciplines. There are no standards established to define success or determine if the patient is appropriate for intervention or continuation of program participation

Prediction: What Change Will Be Tested or Implemented?

- Testing provider referral process to the comprehensive weight management program. Jointly, the CWMP team will present an overview and programming details with a referral process to referring providers at the next quarterly providers meeting

Anticipated Barriers:

- Reluctance to change
- Lack of awareness of program existence
- Limited program enrollment
- Limited staff (RD, clinical PharmD)
- Physician buy-in/participation
- Protocols
- Nursing training (programming process and responsibilities)

DO:

- Number of referrals received
- Number of patients enrolled after being referred
- Number of follow-up visits attended by patients
- Flow of patients from discipline to discipline (RD >PharmD >MD >RN >RD…)
- Compliance with program recommendations and curriculum

STUDY:

Prediction:

- Testing provider referral process to the comprehensive weight management program. Jointly, the CWMP team will present an overview and programming details with a referral process to referring providers at the next quarterly providers meeting.

The Ohio State University Total Health and Wellness Clinic

PLAN:

Current Practices/Processes Related to QI Initiative:

- We are tracking eCQM for BMI quarterly, but percentage is pretty static
- Unsure how consistently providers are using the smartphrase
- The BMI is readily available in the storyboard and is red when it is above 25; however, this can get lost in the amount of information seen in our EMR and providers may miss this

Prediction: What Change Will Be Tested or Implemented?

- We will work with the practice manager and MAs to start including BMI number on the visit note section of the appointment schedule for high-priority visits (patients with a follow-up for DM, HTN, or both). The clinical lead will work with providers on inclusion of that smartphrase in their progress notes. Overall, evaluation will be done by the quality manager to determine what change, if any, was made on the eCQM BMI Screening and Follow-up Plan. Our goal is to have weight management become a more focused topic during visits for chronic conditions can weight can affect

Anticipated Barriers:

- With any new workflow change or addition, there could be some pushback by staff that are affected by the workflow. Staff affected by this workflow include MAs and providers
- We hope to remind providers to use the smartphrase by MAs adding BMI in visit notes. However, there is not a reminder for MAs to be sure to add that into the section. There will likely have to be training and reminders for MAs until it becomes part of their automatic process
- If BMI is not added before provider sees patient, then providers may forget to address with the patient
- Time constraints and busy schedules may affect this

DO:

- To be completed in January 2025.

STUDY:

Prediction:

- We will work with the practice manager and MAs to start including BMI number on the visit note section of the appointment schedule for high-priority visits (patients with a follow-up for DM, HTN, or both). The clinical lead will work with providers on inclusion of that smartphrase in their progress notes. Overall, evaluation will be done by the quality manager to determine what change, if any, was made on the eCQM BMI Screening and Follow-up Plan. Our goal is to have weight management become a more focused topic during visits for chronic conditions can weight can affect

Next and Final Steps

- If your team is interested in scheduling an individual coaching session with the QI Coaches, please use the provided sign-up sheet found under LC 8 postwork
  - These sessions will take place instead of the final two coaching office hours on January 7 and January 14. During the individual team sessions, the QI coaches will provide high-level feedback on your team's final project (Module 7 postwork submission) and recommendations for next steps.
  - The individual office hours are optional.
- Please provide your clinic’s W9 to receive your stipend